- Review record to determine whether there has been a sudden onset or worsening of cognitive symptoms or communication skills following initiation of treatment (e.g., medications)
- Review to determine whether the resident is using any medications known to cause mood shifts, such as psychotropics; antihypertensives, such as clonidine (Catapres), quanethedine (Ismelin), methlydopa (Aldomet), propeneral (Inderal), reserpine; cimetidine (Tagamet); cytoxic agents; digitalis; immunosuppressives; sedatives; steroids; stimulants.

Mood Unimproved and Other Conditions to Consider

The passive resident with distressed mood may be overlooked. Such a resident may be erroneously assumed to have no mood state problem.

- Does the resident show little/no initiative?
- Does he/she remain uninvolved in activities (alone or with others)?
- Is the sad mood persistent?

Does Sad Mood Appear to Respond to Treatment (e.g., Drug Regimen)?

- Has the mood problem remained relatively unchanged for the last 90 days, or has it improved with the current treatment program?
- Have there been cycles of decline and improvement?
- Is resident receiving medications and/or psychosocial therapy?

Confounding Issues:

Are There Indications of New or Intensified Problems With Conditions That May Affect Mood Problems?

These conditions include: Alzheimer's Disease, cancer, cardiac disease, metabolic and endocrine disorders (e.g., hypercalcemia, Cushing's disease, Addison's disease, hypoglycemia, hypokalemia, porphyria), Parkinson's disease, stroke, or other neurological disease, and thyroid disease.

MOOD STATE RAP KEY *(For MDS Version 2.0)*

TRIGGER — REVISION

A mood problem suggested if one or more of following present:

- Resident made negative statements **[E1a = 1,2]**
- Repetitive questions **[E1b = 1,2]**
- Repetitive verbalizations **[E1c = 1,2]**
- Persistent anger with self or others **[E1d = 1,2]**
- Self deprecation **[E1e = 1,2]**
- Expressions of what appear to be unrealistic fears **[E1f = 1,2]**
- Recurrent statements that something terrible is about to happen **[E1g = 1,2]**
- Repetitive health complaints **[E1h = 1,2]**
- Repetitive anxious complaints/concerns **[E1i = 1,2]**
- Unpleasant mood in morning **[E1j = 1,2]**
- Insomnia/change in usual sleep pattern **[E1k = 1,2]**
- Sad, pained, worried facial expressions **[E1l = 1,2]**
- Crying, tearfulness **[E1m = 1,2]**
- Repetitive physical movements[a] **[E1n = 1,2]**
- Withdrawal from activities of interest[b] **[E1o = 1,2]**
- Reduced social interaction **[E1p = 1,2]**
- Mood Persistence **[E2 = 1, 2]**

(a) Note: This item also triggers on the Psychotropic Drug Use RAPs when psychotropic drug use present

(b) Note: This item also triggers on the Psychosocial Well-Being RAP.

GUIDELINES

Indicators of the need to consider a new/altered care strategy:

- Mood decline **[E3]**
- Mood unimproved **[E3]** AND reversible conditions present
  - — Recent move into/within facility **[AB1, Record]**
  - — Delirium **[B5]** Cognitive decline **[B6]**; Delusions **[J1e]**, Hallucinations **[J1i]**,
  - — Communication decline **[C7]**
  - — Grief due to loss **[F2f]**
  - — ADL decline **[G9]**
  - — Use of meds known to cause mood shifts (e.g., antihypertensives, cimetidine, clonidine, cytoxic agents, digitalis, guanethidine, immunosuppressive, methyldopa, nitrates, propranolol, reserpine, steroids, stimulants) **[from record]**
- Mood unimproved **[E3]** AND indication of problem with cognitive ability/memory, decision-making ability, and ability to understand **[B2, B4; C6]** AND ANY of following:
  - — Little or no initiative shown **[F1]**
  - — Little or no involvement in activities **[N2]**
  - — No psychotropic medications **[O4a,b,c]**
  - — No psychological therapy **[P1be]**
- Behavioral or Relationship problems present **[E4; F2]**

Confounding issues to be considered:

- Communication skills **[C4, C5, C6]**
- **Diseases:** Thyroid disease **[I1b,c]**, Cardiac Disease **[I1d - I1k]**, Neurological disease **[I1q to cc]**, Anxiety **[I1dd]**, Depression **[I1ee]**, Manic depression **[I1ff]**, Schizophrenia **[I1gg]**, Cancer **[I1pp]**, Other Psychosis **[I3]**, Hypercalcemia, Cushing's, Addison's, Hypoglycemia, Hypokalemia, Porphyria **[I3]**

Mood State RAP Key 4 of 4

RESIDENT ASSESSMENT PROTOCOL: BEHAVIORAL SYMPTOMS

I. PROBLEM

Between 60% and 70% of residents in a typical nursing facility exhibit emotional, social, and/or behavior disorders; about 40% have purely behavioral symptoms (i.e., wandering, verbal abuse, physically aggressive and/or socially inappropriate behaviors). Residents with behavioral symptoms also frequently have other related problems. Over 80% of those who have behavioral symptoms will have some type of cognitive deficit; about 75% will have mood and/or relationship problems.

Behavioral symptoms are often seen as a source of danger and distress to the residents themselves and sometimes to other residents and staff. Nursing facilities often find such residents difficult to cope with, and physicians often seem unaware of the wide range of available treatment and management options. As a result, overuse of physical restraints or psychotropic drugs is not uncommon. About one-half of residents who exhibit "problem" behaviors will be physically restrained, and about one-half will receive psychoactive medications - antipsychotics (neuroleptics), antianxiety agents, and, to a lesser extent, antidepressants. These interventions, however, have potentially serious negative side-effects, and many nurses in nursing facilities report being uncomfortable using only physical restraints and/or psychotropics to manage residents with behavioral symptoms. As a result, there is an increasing trend toward using other interventions and treatments in addressing behavioral symptoms.

II. TRIGGERS

The MDS trigger items identify two types of residents for whom further review is suggested: residents who exhibit the behavioral symptoms of wandering, being verbally abusive, being physically aggressive and/or exhibiting socially inappropriate behavioral symptoms AND residents who have improved behavioral symptoms but who are receiving treatment or intervention that might mask manifestations of the behavior (e.g., decreased wandering because resident restrained).

Review of behavior status suggested if one or more of following present:

- Wandering*
  [E4aA = 1,2,3]
- Verbally abusive
  [E4bA = 1,2,3]
- Physically abusive
  [E4cA = 1,2,3]
- Socially inappropriate
  [E4dA = 1,2,3]
- Resists Care
  [E4eA = 1,2,3]
- Behavior improved
  [E5 = 1]

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* Note — This Item also triggers on the Fall RAP

Determine the Ways in Which Behavior Problems Impinges on Other Functioning.

Understanding that a behavior can - but does not always - interfere with a resident's self-performance and treatment regimens is useful in considering the need for interventions. This view can also help to ensure that aggressive treatments or interventions (e.g., physical restraints or antipsychotics) are not introduced simply to keep the resident "looking normal."

- Does the behavior endangered the resident? Others? If so, in what ways does it endanger the resident or others?
- Are behavior problems related to daily variations in functional performance? If so, how?
- Does behavior problem lead to resistance to care?
- Does it lead to difficulties dealing with people and coping in the facility?

REVIEW OF POTENTIAL CAUSES OF BEHAVIORAL SYMPTOMS

Many behaviors, however, are problematic for the resident or others. Many are directly associated with acute health conditions, neurological diseases, or psychiatric conditions. Still others originate in the resident's reaction to external factors, such as psychotropic medications, the use of physical restraints, and stressors in the environment (e.g., loud noises, changes in familiar routines). Identifying the various factors involved in the manifestation of behavioral symptoms is critical. Such a process may reveal conditions that can be resolved, thus eliminating or reducing the behavioral symptoms. Further, distinguishing among potential causes or interrelationships is essential to developing an appropriate care plan (e.g., distinguishing between behaviors originating with a neurological condition as contrasted to a psychotic syndrome). Consideration of the items in the Behavioral Symptoms RAP KEY (as well as in related RAPs as indicated) should facilitate this process.

Cognitive Status Problem Interactions.

Decision-making ability is a key indicator of effective cognitive skills. Resolving acute confusional state or delirium, a potentially reversible problem, can be critical to behavior management. (See Delirium RAP if a diagnosis or signs and symptoms of delirium are present.)

For many residents with chronic progressive dementia, certain behaviors may continue in spite of remedial treatments or interventions. In some instances, the behaviors will be distressing; however, in many instances behaviors can be accommodated. For example, many residents who wander can be accommodated without restraints in a hazard-free environment. Similarly, the needs and patterns of demanding residents or those with catastrophic reactions can often be anticipated or the most disrupting reactions to the distress alleviated. The Cognitive Loss/Dementia RAP refers to several issues that can be considered for such residents. Thus, that RAP should be completed prior to this RAP on Behaviors for residents who have cognitive problems.

Presence of Mood and/or Relationship Problem Interactions.

Mood and relationship problems often produce disturbed behavioral symptoms. If the underlying problems are resolved, the behavior may lessen or stop.

- Does the resident have an unresolved mood state or relationship problem that may lead to behavioral symptoms (e.g., anxiety disorder and agitation; depression or isolation and verbally abusive behavior)? Refer to the Psychosocial Well-Being RAP and to the Mood State RAP.

- Is there an association among mood state, relationship, and behavioral symptoms?
- Can a cause and effect relationship be determined?
- Does the resident experience a sense of frustration because of rejection by family? If so, does this frustration result in the resident verbally abusing staff or other residents?

Relationship Difficulties That May Affect Behavior.

- Does the presence or absence of other persons precipitate an event?
- Was a combative act prompted by paranoid delusions about another's motives or actions?
- Did recent loss of loved one, change in staff, an intrafacility move, or placement with a roommate with whom the resident cannot communicate lead to disruptive behavioral symptoms?

Environmental Conditions.

A review of the resident's behaviors over time may, as noted earlier, reveal a pattern of behaviors that helps identify the causes of the behaviors. Because environmental conditions often have a profound effect on residents' behaviors, these factors should be given special consideration.

- Are staff sufficiently responsive? Do they recognize stressors for the resident and early warning signs of problem behavior?
- Do staff follow the resident's familiar routines?
- Do noise, crowding or dimly lit areas affect resident's behavior?
- Are other residents physically aggressive?

Illness/Conditions.

Sometimes, the onset of acute illnesses and/or the worsening of a chronic illness produces disturbed behaviors. Often identification and treatment of the illness will resolve the problem behavior. In addition, a resident with certain chronic conditions, particularly difficulties in making his/her needs understood or in understanding others may also exhibit problem behaviors that can be eliminated or reduced if more effective methods of communication are adopted by staff and families. Sensory impairments (vision,hearing) may also produce disruptive behaviors that would lessen or disappear if the underlying condition were addressed.

- Can physical health factors close in time to the disturbed behavior be identified (e.g., pain or discomfort from physical conditions such as arthritis, constipation, or headache)?
- Can the observed behavior be associated with an acute illness(e.g., urinary tract infection, other infections, fever, hallucinations/delusions, sleep deprivation, fall with physical trauma, nutritional deficiencies, weight loss, dehydration/insufficient fluids, electrolyte disorder, or acute hypotension)?
- Can the observed behavior be associated with the worsening of a chronic illness (e.g., congestive heart failure, diabetes, psychoses, Alzheimer's disease or other dementia, CVA, or hypoglycemia for a diabetic)?
- What was the role of impaired hearing, vision, or ability to communicate or understand others?

Current Treatment/Management Procedures: Positive and Negative Consequences.

A number of treatment or management interventions may affect a resident's behavior. Some may have had a positive effect, while others may exacerbate existing behavioral symptoms - or produce new problems. Both are important to consider in reaching a decision about whether to proceed with a care plan intervention. For example, review the resident's interest in, use of, or participation in psychological treatment program(s). This review will be especially important for residents who have recently experienced improved behavioral status. For some residents and some management programs, continuation of treatments may be central to maintaining their new-found control. In other cases, either the interventions can be reduced (at least on a trial basis), or the side effects of the intervention may be so severe that alterations in the treatment regimen should be considered. For example, a drug or restraint program may result in increased confusion and agitation, reduced ADL self-performance, a decline in mood, or a general decrease in the quality of life for the resident. On the other hand, breaking tasks of daily life down into smaller steps that the resident can comprehend and perform may reduce stress and prevent problem behavior.

- Has the resident been evaluated by a psychiatrist, etc.? When?
- Are there indicators that treatments have helped resident gain increased control over life? What were they?
- Can improvement be attributed to an identifiable treatment?
- If behavioral symptoms have decreased, can medication or behavior management programs be withdrawn?
- Is the onset or change of behaviors associated with the start of (or change in prescription of) a medication(s)?
- Is the behavior associated with the use of a physical restraint (e.g., increased agitation and anger)?
- Has the resident received care in a specially designed therapeutic unit?
- Are there special staff training/support programs that focus on managing behavioral symptoms?
- What disciplines are involved? How frequent/consistent is the training?
- Has task segmentation been used to maximize resident involvement?

BEHAVIORAL SYMPTOMS RAP KEY *(For MDS Version 2.0)*

TRIGGER — REVISION

Review of behavior status suggested if one or more of following present:

- Wandering*
  [E4aA = 1,2,3]
- Verbally abusive
  [E4bA = 1,2,3]
- Physically abusive
  [E4cA = 1,2,3]
- Socially inappropriate
  [E4dA = 1,2,3]
- Resists Care
  [E4eA = 1,2,3]
- Behavior improved
  [E5 = 1]

* Note — This Item also triggers on the Fall RAP

GUIDELINES

Review and describe behavioral symptom:

- **Evaluating the seriousness and stability/change of behavioral symptoms.** Review of intensity, duration, frequency and, if any, pattern of behaviors, their development over time, and their effect on the resident and others **[E4aB, E4bB, E4cB, E4dB, E4eB, from record]**.

Review potential causes that could be addressed or resolved:

- **Cognitive status problems.** Delirium **[B5]**, Alzheimer's Disease **[I1q]** or other dementia **[I1u]**, Effects of stroke **[C4, C5, C6; G5, G6; I1r, I1t]**.

- **Mood or relationship problems.** Sad or anxious mood **[E1]**, Unsettled relationships **[F2]**, Psychiatric diagnosis **[I1dd, I1ee, I1ff, I1gg]**

- **Environmental conditions.** Departure from resident's normal routines prior to entering facility **[F3c]**, Staff responses, presence of stressful conditions of physically aggressive resident **[from record, interviews with staff, resident]**

- **Illness/conditions.** Onset of acute illness, worsening of chronic illness **[J5a,b]**, and other related problems, such as Constipation **[H2b]**, Diabetes **[I1a]**, CHF **[I1f]**, Pneumonia **[I2e]**, Septicemia **[I2g]**, UTI **[I2j]** or other infection **[I2, I3]**, Fever **[J1h]**, Delusions **[J1e]**, Hallucinations **[J1i]**, Pain **[J2]**, Fall with physical trauma to head **[J4a,b; I1cc]**

- **Communication deficits.** Difficulty making self understood **[C4]** or Understanding others **[C6]**

- **Sensory impairments.** Hearing problem **[C1]**, Visual problem **[D1]**, Visual Limitations **[D2]**

- **Treatment/management procedures.** Antipsychotics, antianxiety, antidepressants, hypnotics **[O4a,b,c,d]**, Behavior management program **[P2]**, Trunk, limb or chair restraints **[P4c,d,e]**

Behavioral Symptoms RAP Key 6 of 6

RESIDENT ASSESSMENT PROTOCOL: ACTIVITIES

I. PROBLEM

The Activities RAP targets residents for whom a revised activity care plan may be required to identify those residents whose inactivity may be a major complication in their lives. Resident capabilities may not be fully recognized: the resident may have recently moved into the facility or staff may have focused too heavily on the instrumental needs of the resident and may have lost sight of complications in the institutional environment.

Resident involvement in passive as well as active activities can be as important in the nursing home as it was in the community. The capabilities of the average resident have obviously been altered as abilities and expectations change, disease intervenes, situational opportunities become less frequent, and extended social relationships less common. But something that should never be overlooked is the great variability within the resident population: many will have ADL deficits, but few will be totally dependent; impaired cognition will be widespread, but so will the ability to apply old skills and learn new ones; and sense may be impaired, but some type of two-way communication is almost always possible.

For the nursing home, activity planning is a universal need. For this RAP, the focus is on cases where the system may have failed the resident, or where the resident has distressing conditions that warrant review of the activity care plan. The types of cases that will be triggered are: (1) residents who have indicated a desire for additional activity choices; (2) cognitively intact, distressed residents who may benefit from an enriched activity program; (3) cognitively deficient, distressed residents whose activity levels should be evaluated; and (4) highly involved residents whose health may be in jeopardy because of their failure to "slow down."

In evaluating triggered cases, the following general questions may be helpful:

- Is inactivity disproportionate to the resident's physical/cognitive abilities or limitations?
- Have decreased demands of nursing home life removed the need to make decisions, to set schedules, to meet challenges? Have these changes contributed to resident apathy?
- What is the nature of the naturally occurring physical and mental challenges the resident experiences in everyday life?
- In what activities is the resident involved? Is he/she normally an active participant in the life of the unit? Is the resident reserved, but actively aware of what is going on around him/her? Or is he/she unaware of surroundings and activities that take place?
- Are there proven ways to extend the resident's inquisitive/active engagement in activities?
- Might simple staff actions expedite resident involvement in activities? For example: Can equipment be modified to permit greater resident access of the unit? Can the resident's location or position be changed to permit greater access to people, views, or programs? Can time and/or distance limitations for activities be made less demanding without destroying the challenge? Can staff modes of interacting with the resident be more accommodating, possibly less threatening, to resident deficits?

II. TRIGGERS

ACTIVITIES TRIGGER A (Revise)

Consider revising activity plan if one or more of following present:

- Involved in activities little or none of time
  [N2 = 2, 3]
- Prefers change in daily routine
  [N5a = 1,2]
  [N5b = 1,2]

ACTIVITIES TRIGGERS B (Review)

Review of activity plan suggested if both of following present:

- Awake all or most of time in morning
  [N1a = checked]
- Involved in activities most of time
  [N2 = 0]

III. GUIDELINES

The followup review looks for factors that may impede resident involvement in activities. Although many factors can play a role, age as a valid impediment to participation can normally be ruled out. If age continues to be linked as a major cause of lack of participation, a staff education program may prove effective in remedying what may be overprotective staff behavior.

Issues to be Considered as Activity Plan is Developed.

Is Resident Suitably Challenged, Overstimulated? To some extent, competence depends on environmental demands. When the challenge is not sufficiently demanding, a resident can become bored, perhaps withdrawn, may resort to fault-finding and perhaps even behave mischievously to relieve the boredom. Eventually, such a resident may become less competent because of the lack of challenge. In contrast, when the resident lacks the competence to meet challenges presented by the surroundings, he or she may react with anger and aggressiveness.

- Do available activities correspond to resident lifetime values, attitudes, and expectations?
- Does resident consider "leisure activities" a waste of time - he/she never really learned to play, or to do things just for enjoyment?
- Have the resident's wishes and prior activity patterns been considered by activity and nursing professionals?
- Have staff considered how activities requiring lower energy levels may be of interest to the resident - e.g., reading a book, talking with family and friends, watching the world go by, knitting?
- Does the resident have cognitive/functional deficits that either reduce options or preclude involvement in all/most activities that would otherwise have been of interest to him/her?

Confounding Problems to be Considered.

Health-related factors that may affect participation in activities. Diminished cardiac output, an acute illness, reduced energy reserves, and impaired respiratory function are some of the many reasons that activity level may decline. Most of these conditions need not necessarily incapacitate the resident. All too often, disease-induced reduction of activity may lead to progressive decline through disuse, and further decrease in activity levels. However, this pattern can be broken: many activities can be continued if they are adapted to require less exertion or if the resident is helped in adapting to a lost limb, decreased communication skills,new appliances, and so forth.

- Is resident suffering from an acute health problem?
- Is resident hindered because of embarrassment/unease due to presence of health-related equipment (tubes, oxygen tank, colostomy bag, wheelchair)?
- Has the resident recovered from an illness? Is the capacity for participation in activities greater?
- Has an illness left the resident with some disability (e.g., slurred speech, necessity for use of cane/walker/wheelchair, limited use of hands)?
- Does resident's treatment regimen allow little time or energy for participation in preferred activities?

Other Issues to be Considered.

Recent decline, in resident status — cognition, communication, function, mood, or behavior. When pathologic changes occur in any aspect of the resident's competence, the pleasurable challenge of activities may narrow. Of special interest are problematic changes that may be related to the use of psychoactive medications. When residents or staff overreact to such losses, compensatory strategies may be helpful - e.g., impaired residents may benefit from periods of both activity and rest; task segmentation can be considered; or available resident energies can be reserved for pleasurable activities (e.g., using usual stamina reserves to walk to the card room, rather than to the bathroom) or activities that have individual significance (e..g, sitting unattended at a daily prayer service rather than at group activity program).

- Has staff or the resident been overprotective? Or have they misread the seriousness of resident cognitive/functional decline? In what ways?
- Has the resident retained skills, or the capacity to learn new skills, sufficient to permit greater activity involvement?
- Does staff know what the resident was like prior to the most recent decline? Has the physical/other staff offered a prognosis for the resident's future recovery, or change of continued decline?
- Is there any substantial reason to believe that the resident cannot tolerate or would be harmed by increased activity levels? What reasons support a counter opinion?
- Does resident retain any desire to learn or master a specific new activity? Is this realistic?
- Has there been a lack of participation in the majority of activities which he/she stated as preference are as even though these types of activities are provided?

Environmental factors. Environmental factors include recent changes in resident location, facility rules, season of the year, and physical space limitations that hinder effective resident involvement.

- Does the interplay of personal, social, and physical aspects of the facility's environment hamper involvement in activities? How might this be addressed?
- Are current activity levels affected by the season of the year or the nature of the weather during the MDS assessment period?
- Can the resident choose to participate in or to create an activity? How is this influenced by facility rules?
- Does resident prefer to be with others, but the physical layout of the unit gets in the way? Do other features in the physical plant frustrate the resident's desire to be involved in the life of the facility? What corrective actions are possible? Have any been taken?

Changes in availability of family/friends/staff support. Many residents will experience not only a change in residence but also a loss of relationships. When this occurs, staff may wish to consider ways for resident to develop a supportive relationship with another resident, staff member or volunteer that may increase the desire to socialize with others and/or to participate in activities with this new friend.

- Has a staff person who has been instrumental in involving a resident in activities left the facility/been reassigned?
- Is a new member in a group activity viewed by a resident as taking over?
- Has another resident who was a leader on the unit died or left the unit?
- Is resident shy, unable to make new friends?
- Does resident's expression of dissatisfaction with fellow residents indicate he/she does not want to be a part of an activities group?

Possible Confounding Problems to be Considered for Those Now Actively Involved in Activities. Of special interest are cardiac and other diseases that might suggest a need to slow down.

ACTIVITIES RAP KEY *(For MDS Version 2.0)*

TRIGGER — REVISION

ACTIVITIES TRIGGER A (Revise)

Consider revising activity plan if one or more of following present:

- Involved in activities little or none of time
  [N2 = 2, 3]
- Prefers change in daily routine
  [N5a = 1,2]
  [N5b = 1,2]

ACTIVITIES TRIGGERS B (Review)

Review of activity plan suggested if both of following present:

- Awake all or most of time in morning
  [N1a = checked]
- Involved in activities most of time
  [N2 = 0]

GUIDELINES

Issues to be considered as activity plan is developed:

- Time in facility **[AB1]**
- Cognitive status **[B2, B4]**
- Walking/locomotion pattern **[G1c,d,e,f]**
- Unstable acute/chronic health conditions **[J5a,b]**
- Number of treatments received **[P1]**
- Use of Psychoactive medications **[O4a,b,c,d]**

Confounding problems to be considered:

- Performs tasks slowly and at different levels (reduced energy reserves) **[G8c,d]**
- Cardiac dysrhythmias **[I1e]**
- Hypertension **[I1h]**
- CVA **[I1t]**
- Respiratory diseases **[I1hh,I1ii]**
- Pain **[J2]**

Other issues to be considered:

- Customary routines **[AC]**
- Mood **[E1, E2]** and Behavioral Symptoms **[E4]**
- Recent loss of close family member/friend or staff **[F2f; from record]**
- Whether daily routine is very different from prior pattern in the community **[F3c]**

Activities RAP Key 5 of 5

RESIDENT ASSESSMENT PROTOCOL: FALLS

I. PROBLEM

Falls are a common source of serious injury and death among the elderly. Each year, 40% of nursing home residents fall. Up to 5% of falls result in fractures; an additional 15% result in soft tissue injuries. Moreover, most elders are afraid of falling, and this fear can limit their activities.

In about one-third of falls, a single potential cause can be identified; in two-thirds, more than one risk factor will be involved. Risk factors that are internal to the resident include the resident's physical health and functional status. External risk factors include medication side effects, the use of appliances and restraints, and environmental conditions. Identification and assessment of those who have fallen and those who are at high risk of falling are the goals of this RAP.

II. TRIGGERS

Potential for Additional Falls [A] or Risk of Initial Fall [R] suggested if one or more of following present:

- *Fell in past 30 days (Additional)* [c]
  [J4a = checked]
- Fell in past 31-180 days (*Additional*) [c]
  [J4b = checked]

- Wandering [a] *(Risk)*
  [E4aA = 1,2,3]
- Dizziness (*Risk*) [c]
  [J1f = checked]
- Use of trunk restraint (*Risk*) [b]
  [P4c = 1,2]
- Use of Antianxiety drugs (*Risk*)[d]
  [O4b = 1-7]
- Use of Antidepressant drugs (*Risk*)[d]
  [O4c = 1-7]

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[a] Note: This item also triggers on the Behavior Symptom RAP.
[b] Note: Code 2 also triggers on the Pressure Ulcer RAP. Both codes trigger on the Physical Restraint RAP.
[c] Note: This item also triggers on the Psychotropic Drug Use RAP (when psychotropic drugs present).
[d] When present with specific condition, this item is part of trigger on Psychotropic Drug Use RAP.

III. GUIDELINES

To reach a decision on a care plan, begin by reviewing whether one or more of the major risk factors listed on the RAP KEY are present. Clarifying information on the nature of the risk or type of issue to be considered for the RAP KEY items follows.

Multiple Falls: Is There a Previous History of Falls, or was the Fall an isolated Event?

Refer to the MDS, reports of the family, and incident reports.

Internal Risk Factors.

Review to determine whether the items listed on the RAP KEY under the following headings are present. Each of these represents an underlying health problem or condition that can cause falls and may be addressed so as to prevent future falls.

- *Cardiovascular*
- *Neuromuscular/functional*
- *Orthopedic*
- *Perceptual*
- *Psychiatric or cognitive*

External Risk Factors.

These risk factors can often be modified to reduce the resident's risk of falls.

Medications. Certain drugs can produce falls by causing related problems (hypotension, muscle rigidity, impaired balance, other extrapyramidal side effects [e.g., tremors], and decreased alertness). These drugs include: antipsychotics, antianxiety/hypnotics, antidepressants, cardiovascular medications, and diuretics.

- Were these medications administered prior to or after the fall?
- If prior to the fall, how close to it were they first administered?

Appliances and Devices.

- If the resident who falls (or is at risk of falling) uses an appliance observe his/her use of the appliance for possible problems.
- Review the MDS and the resident's record to determine whether restraints were used prior to the fall and might have contributed to the fall, (e.g., causing a decline function or an increase in agitation).

Environmental/Situational Hazards. Many easily modifiable hazards (e.g., poor lighting, patterned carpeting, poorly arranged furniture) in the environment may cause falls both in relatively healthy and in frail elderly residents.

For Those Who Have Fallen Previously, Review the Circumstances Under Which the Fall Occurred.

Attempt to gather information on most recent fall. Needed information includes:

- Time of day, time since last meal.
- Was resident doing usual or unusual activity?
- Was he/she standing still or walking? Reaching up or down? Not reaching?
- Was resident in a crowd of people? Responding to bladder/bowel urgency?
- Was there glare or liquid on floors? Foreign objects in walkway? New furniture placement or other changes in environment?
- Is there a pattern of falls in any of the above circumstances?
- If you know what the resident was doing during the fall, have her/him perform that activity and observe (protect resident to ensure that a fall does not occur during this test).

Take necessary vital signs:

- At time of fall, obtain supine and upright blood pressure and heart rate, IF the resident does not have a serious injury such as a fracture of the hip or lower extremity.
- When reproducing circumstances of a fall (e.g., if the resident fell 10 minutes after eating a large meal, take vital signs 10 minutes after the residents eats).
- Measure blood pressure and heart rate when the resident is supine AND 1 and 3 minutes after standing; note temperature and respiratory rate.

For Residents At Risk of Future Falls, Review Environmental/Situational Factors to Determine Whether Modifications Are Needed

- Observe resident's usual pattern of interaction with his/her environment – the way he/she gets out of bed, walks, turns, gets in and out of chairs, uses the bathroom. Observations may reveal environmental solutions to prevent falls.
- Observe him/her get out of bed, walking 20 feet, turn in a 360° circle, standing up from a chair without pushing off with his/her arms (fold arms in front), and using the bathroom.

FALLS RAP KEY *(For MDS Version 2.0)*

TRIGGER — REVISION

Potential for Additional Falls or Risk of Initial Fall suggested if one or more of following present:

- Fell in past 30 days (*Additional*) [c]
  [J4a = checked]
- Fell in past 31-180 days (*Additional*) [c]
  [J4b = checked]

- Wandering [a] *(Risk)*
  [E4aA = 1,2,3]
- Dizziness (*Risk*) [c]
  [J1f = checked]
- Use of trunk restraint (*Risk*) [b]
  [P4c = 1,2]
- Use of Antianxiety drugs (*Risk*)[d]
  [O4b = 1-7]
- Use of Antidepressant drugs (*Risk*)[d]
  [O4c = 1-7]

[a] Note: This item also triggers on the Behavior Symptom RAP.

[b] Note: Code 2 also triggers on the Pressure Ulcer RAP. Both codes trigger on the Physical Restraint RAP.

[c] Note: This item also triggers on the Psychotropic Drug Use RAP (when psychotropic drugs present).

[d] When present with specific condition, this item is part of trigger on Psychotropic Drug Use RAP

GUIDELINES

Review risk factors for falls to identify problems that may be addressed/resolved:

- **Multiple Falls. [J4a, J4b]**

- **Internal Risk Factors.**
  - *Cardiovascular:* Cardiac dysrhythmia **[I1e]**
  - *Neuromuscular/functional:* Loss of arm or leg movement **[G4b,d]**, Decline in functional status **[G9]**, Incontinence **[H1]**, Hypotension **[I1i]**, CVA **[I1t]**, Hemiplegia/Hemiparesis **[I1v]**, Parkinson's **[I1y]**, Seizure disorder **[I1aa]**, Syncope **[J1m]**, Chronic/acute condition makes unstable **[J5a, J5b]**, Unsteady gait **[J1n]**,
  - *Orthopedic:* Joint pain **[J3g]**, Arthritis **[I1l]**, Fracture of the hip **[I1m, J4c]**, Missing limb (e.g., amputation) **[I1n]**, Osteoporosis **[I1o]**
  - *Perceptual:* Impaired hearing **[C1]**, Impaired vision **[D1, D2]**, Dizziness/vertigo **[J1f]**
  - *Psychiatric or cognitive*: Delirium **[B5]**, Decline in cognitive skills **[B6]**, Manic depression **[I1ff]**, Alzheimer's **[I1q]**, Other Dementia **[I1u]**

- **External Factors**
  - *Medications*: Psychotropic meds **[O4a,b,c,d]** Cardiovascular meds **[from record]** and Diuretics **[O4e]**
  - *Appliances/devices* (time started): Pacemaker **[from record]**; Cane/walker/crutch **[G5a]**; Devices and restraints **[P4a,b,c,d,e]**
  - *Environmental/situational hazards and, if relevant, circumstances of recent fall(s):* **[Review of situation and environment]** glare; poor illumination; slippery floors; uneven surfaces; patterned carpets; foreign objects in walkway; new arrangement of objects; recent move into/within facility; proximity to aggressive resident; time of day; time since meal; type of activity; standing still/walking in a crowded area/ reaching/not reaching; responding to bladder/bowel urgency.

FALLS RAP Key 4 of 4

RESIDENT ASSESSMENT PROTOCOL: NUTRITIONAL STATUS

I. PROBLEM

Malnutrition is not a response to normal aging; it can arise from many causes. Its presence may signal the worsening of a life-threatening illness, and it should always be seen as a dramatic indicator of the resident's risk of sudden decline. Severe malnutrition is, however, relatively rare, and this RAP focuses on signs and symptoms that suggest that the resident may be at risk of becoming malnourished. For many who are triggered, there will be no obvious, outward signs of malnutrition. Prevention is the goal, and early detection is the key.

Early problem recognition can help to ensure appropriate and timely nutritional intervention. For many residents, simple adjustments in feeding patterns may be sufficient. For others, compensation or correction for food intake problems may be required.

Within a nutrition program, food intake is best accomplished via oral feedings. Tube (enteral) feeding is normally limited to residents who have a demonstrated inability to orally consume sufficient food to prevent major malnutrition or weight loss. Parenteral feeding is normally limited to life-saving situations where both oral and enteral feeding is contraindicated or inadequate to meet nutrient needs. Oral feeding is clearly preferred. Depending on the nature of the problem, residents can be encourage to use finger foods; to take small bites; to use the tongue to move food in the mouth from side to side; to chew and swallow each bite; to avoid food that causes mouth pain, etc. Therapeutic programs can also be designed to review for the need for adaptive utensils to compensate for problems in sucking, closing lips, or grasping utensils; to help the confused resident maintain a fixed feeding routine, etc.

II. TRIGGERS

Malnutrition problem suggested if one or more of following observed

- Weight loss
  [K3a = 1]
- Complains about taste of many foods
  [K4a = checked]
- Leaves 25% or more food uneaten at most meals
  [K4c = checked]
- Parenteral/IV feeding[a]
  [K5a = checked]
- Mechanically altered diet
  [K5c = checked]
- Syringe (oral feeding)
  [K5d = checked]
- Therapeutic diet
  [K5e = checked]
- Pressure ulcer[b]
  [M2a = 2, 3, or 4]

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[a] Note: These items also trigger on the Dehydration/Fluid Maintenance RAP.
[b] Note: These items also trigger on the Pressure Ulcer RAP

III. GUIDELINES

RESIDENT FACTORS THAT MAY IMPEDE ABILITY TO CONSUME FOOD

Reduced ability to feed self

Reduced ability to feed self can be due to arthritis, contractures, partial or total loss of voluntary arm movement, hemiplegia or quadriplegia, vision problems, inability to perform activities of daily living without significant assistance, and coma.

Chewing problems

Residents with oral abscesses, ill-fitting dentures, teeth that are broken, loose, carious or missing, or those on mechanically altered diets frequently cannot eat enough food to meet their calorie and other nutrient needs. Significant weight loss can, in turn, result in poorly fitting dentures and infections that can lead to more weight loss.

Losses from diarrhea or an ostomy

Swallowing problems

Swallowing problems arise in several contexts: the long-term result of chemotherapy, radiation therapy, or surgery for malignancy (including head and neck cancer); fear of swallowing because of COPD/emphysema/asthma; stroke; hemiplegia or quadriplegia; Alzheimer's disease or other dementia; and ALS.

Possible Medical Causes

Numerous conditions and diseases can result in increased nutrient requirements (calories, protein, vitamins, minerals, water, and fiber) for residents. Among these are cancer and cancer therapies, Parkinson's disease with tremors, septicemia, pneumonia, gastrointestinal influenza, fever, vomiting, diarrhea and other forms of malabsorption including excessive nutrient loss from ostomy, burns, pressure ulcers, COPD/emphysema/asthma, Alzheimer's disease with concomitant pacing or wandering, and hyperthyroidism.

Malignancy and nutritional consequences of chemotherapy, radiation therapy/surgery. For the resident undergoing therapy aimed at remission or cure, aggressive nutritional support is necessary to achieve the goal; for the resident with incurable malignancy who is undergoing palliative therapy or is not responding to curative therapy, aggressive nutritional support is often medically inappropriate.

- Have the wishes of the resident and family concerning aggressive nutritional support been ascertained?

Anemia (nutritional deficiency, not malnutrition). A hematocrit of less than 41% is predictive of increased morbidity and mortality for residents.

- Are shortness of breath, weakness, paleness of mucous membranes and nailbeds, and/or clubbing of nails present?

Chronic COPD increases calorie needs and can be complicated by an elevated fear of choking when eating or drinking.

Shortness of breath (frequently seen with congestive heart failure, hypertension, edema, and COPD/emphysema/asthma). This is another condition that can cause a fear of eating and drinking, with a consequent reduction in food intake.

Constipation/intestinal obstruction/pain can inhibit appetite

Drug-induced anorexia often causes decreased or altered ability to taste and smell foods.

Delirium

PROBLEMS TO BE REVIEWED FOR POSSIBLE RELATIONSHIP TO NUTRITIONAL STATUS PROBLEM (Causal link)

Mental problems.

Mental retardation, Alzheimer's or other dementia, depression, paranoid fears that food is poisoned, and mental retardation can all lead to anorexia, resulting in significant amounts of uneaten food and subsequent weight loss.

Behavior patterns and problems.

Residents who are fearful, who pace or wander, withdraw from activities, cannot communicate, or refuse to communicate, often refuse to eat or will eat only a limited variety and amount of foods. Left untreated, behavior problems that result in refusal to eat can cause significant weight loss and subsequent malnutrition.

- Does resident use food to gain staff attention?
- Is resident unable to undertand the importance of eating?

Inability to Communicate.

For most residents, enjoying food and mealtimes crucially affects quality of life. Inability to make food and mealtime preferences known can result in a resident eating poorly, losing weight, and being unhappy. Malnutrition due to poor communication usually indicates substandard care. Early correction of communication problems, where possible, can prevent malnutrition.

- Does the area in which meals are served lend itself to socialization among residents? Is it a place where social communication can easily take place?
- Has there been a failure to provide adequate staff and/or adequate time in feeding or assisting residents to eat?
- Has there been a failure to recognize the need and supply adaptive feeding equipment for residents who can be helped to self-feed with such assistance?
- Is the resident capable of telling staff that he/she has a problem with the food being served- e.g., finds it to be unappetizing or unattractively presented?

Amputation

Weight loss may be due to an amputation.

Chronic COPD increases calorie needs and can be complicated by an elevated fear of choking when eating or drinking.

Shortness of breath (frequently seen with congestive heart failure, hypertension, edema, and COPD/emphysema/asthma). This is another condition that can cause a fear of eating and drinking, with a consequent reduction in food intake.

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- Has there been a failure to recognize the need and supply adaptive feeding equipment for residents who can be helped to self-feed with such assistance?
- Is the resident capable of telling staff that he/she has a problem with the food being served- e.g., finds it to be unappetizing or unattractively presented?

Amputation

Weight loss may be due to an amputation.

NUTRITIONAL STATUS RAP KEY *(For MDS Version 2.0)*

TRIGGER — REVISION

Malnutrition problem suggested if one or more of following observed

- Weight loss
  [K3a = 1]
- Complains about taste of many foods
  [K4a = checked]
- Leaves 25% or more food uneaten at most meals
  [K4c = checked]
- Parenteral/IV feeding[a]
  [K5a = checked]
- Mechanically altered diet
  [K5c = checked]
- Syringe (oral feeding)
  [K5d = checked]
- Therapeutic diet
  [K5e = checked]
- Pressure ulcer[b]
  [M2a = 2, 3, or 4]

GUIDELINES

Factors that impede ability to consume foods:

- Reduced ability to feed self **[G1h]**
- Ostomy losses **[H3i]**,
- Chewing problems **[K1a]**
- Swallowing problems **[K1b]**
- **Possible medical causes:** Diarrhea **[H2c]**, Anemia **[I1oo]**, Cancer **[I1pp]**, Pneumonia **[I2e]**, Fever **[J1h]**, Shortness of breath **[J1l]**, Chemotherapy **[P1a]**, and nutrient/medication interactions (e.g., anti-psychotics **[O4a]**, cardiac drugs, diuretics **[O4e]**, laxatives, antacids) **[from record]**

Problems to be reviewed for possible relationship to nutritional status problem:

- **Mental problems:** Mental retardation **[AB10]**, Fear that food is poisoned **[from record; E1]**; Alzheimer's Disease **[I1q]**, Other dementia **[I1u]**; Anxiety disorders **[I1dd]**; Depression **[I1ee]**;
- **Behavior problems:** Pacing **[E1n]**, Withdrawal from activities of interest **[E1o]**, Wandering **[E4a]**, Throwing food **[E4d]**, Slowness in self feeding **[G8c]**, Leaves 25% or more food uneaten **[K4c]**
- **Inability to communicate:** Comatose **[B1]**, Unable to make food and mealtime preferences known **[C3g]**, and Difficulty making self understood **[C4]**, Difficulty understanding others **[C6]**, Aphasia **[I1r]**
- **Functional problems:** Loss of upper extremity use **[G4a,b,c]**, Amputation **[I1n]**

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[a] Note: These items also trigger on the Dehydration/Fluid Maintenance RAP

[b] Note: These items also trigger on the Pressure Ulcer RAP

RAP Key 4 of 4